15.04.01 MEDICARE

A. General

This section provides staff with information about Medicare. It describes Medicare Buy-In, the process in which DHCS pays premiums for Medicare Part B for some qualified Medi-Cal beneficiaries.

Medicare is a federally administered health insurance program for qualified persons. Medicare benefits are divided into three parts: MEM Proc. 15F

1. Part A - Hospital Insurance
2. Part B - Supplementary Medical Insurance
3. Part D - Prescription Drug Coverage

B. Medicare Part A Benefits

Coverage

Part A covers most of the costs for inpatient hospital care, extended care facilities, home health agency services and outpatient visits after the beneficiary is discharged from a hospital or extended care facility. It does not cover doctors' services, even for hospital visits.

Payment

DHCS does not establish Part A premium payments. Beneficiaries establish eligibility to Medicare Part A benefits by their:

- Social Security quarters coverage; or
- Direct premium payment for benefits

C. Medicare Part B Benefits

Coverage

After the beneficiary pays the required deductible amount, Part B medical insurance pays 80 percent of the reasonable charges for most non-institutional medical services such as physician services, home health agency services and drugs which cannot be self administered. A zero SOC Medi-Cal card may pay both the deductible and charges over 80 percent for Medicare beneficiaries.

Payment of Premiums

- This is a voluntary health insurance program, financed by premiums from qualified enrollees and supplementary federal funds. ACWDL 08-48
- DHCS pays these premiums for eligible Medi-Cal and SSI/SSP

beneficiaries with a SOC at or below $500 under the Buy-In Program.

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D. Part B Premiums for Beneficiaries with a SOC over $500

ACWDL 08-48

Effective December 2008, when a beneficiary's SOC increases over $500, DHCS will not request Buy-In for that individual.

SSA will deduct the Part B premium amount from the beneficiaries' SSA the month following the SOC increase. This should be counted in the Medi-Cal budget as a Medical insurance deduction.

When beneficiaries receive a deduction because they paid their own Medicare premium and the payment of that premium either:

- Reduces their SOC to $500 or less, or
- Makes them eligible for the Aged and Disabled Federal Poverty Level Program; then

DHCS will pay their premium for that month retroactively. The beneficiary will be reimbursed for that month through their SSA benefit retroactively. When the reimbursement is received, it must be counted as property in the month of receipt.

When workers receive alert…	**Then workers…**
8010 indicating that DHCS is **no longer** paying the medicare premium.	Must add the premium payment as a health insurance deduction for the following month. No 10 day notice is required to reduce the SOC.
8004 indicating that DHCS **is** paying the Buy-In	Must remove the premium payment as a health insurance deduction. This change is an increase in the SOC, so 10 day notice is necessary.

MPG Letter #661 (12/08)

E. Part B Premiums for Beneficiaries with a SOC over $500 SOC Met

ACWDL 08-48

Effective December 2008, DHCS does not pay Part B premiums for applicants and beneficiaries with a SOC over $500 until or unless the SOC is met on a monthly basis. Below are some common examples of meeting the SOC:

- Nursing home residents who regularly meet their SOC will have their Part B premiums paid for those individuals who are certified on

the first of each month.

- IHSS recipients who regularly meet their SOC will have their Part B premiums paid for those months when the SOC is met.

- A beneficiary with a Medi-Cal SOC over $500 and an IHSS SOC below $500 must meet the Medi-Cal SOC before Medi-Cal will pay the Part B premium. *(Even if their IHSS SOC is lower than $500, DHCS will not pay part B premiums for beneficiaries of In-Home Supportive Services if their Medi-Cal SOC is over $500.)*

The deadline for reporting a met SOC to MEDS for DHCS to request Buy-In for the next month is the 20th.

MPG Letter #661 (12/08)

E. Ping Pong Effect for Beneficiaries with a SOC over $500

ACWDL 08-48

There are some cases where allowing the Part B premium deduction will reduce the SOC enough that DHCS will begin to pay the Part B premiums (SOC is reduced below $500 or beneficiaries are MSP eligible). However, once the Part B premium is paid by DHCS, the beneficiary will no longer be entitled to the deduction, which creates an increased in SOC or ineligibility to MSP. This ineligibility forces DHCS to discontinue premium payments, starting the cycle all over again.

Example:

November

A SOC of $590 is reported to MEDS November 7th. The premium deduction is $100.

December

We know that SSA will deduct the Part B premium amount from beneficiaries' SSA check December 1, so we budget the $100 medical insurance deduction and we get a SOC of $490. That SOC is reported to MEDS prior to MEDS cutoff for December. DHCS requests the Buy-In for January.

January

DHCS Medicare Buy-In is in effect. Since DHCS is paying the Part B premium, the medical insurance deduction for Part B premium will be removed from the January budget and the SOC for January will increase to $590. Based on January SOC of $590, DHCS does not request Buy-In for February.

February

Since DHCS did not request Buy-In for February, SSA will deduct the premium amount from beneficiaries' SSA February check February 1, so we budget the $100 medical insurance deduction and arrive at the SOC of $490 reported to MEDS for February. DHCS requests Buy-In for March.

Staff must make the changes to the budget as they receive the MEDS alerts, bearing in mind that any increase in the Medi-Cal SOC requires a 10 day notice.

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F. Required Assistance for beneficiaries with a SOC over $500

Workers must take the following actions to assist affected beneficiaries:

ACWDL 08-48

Step	Action

	premium increase for each 12-month period they were eligible, but did not enroll in Medicare Part B.

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E. Medicare Part D Benefits

ACWDL 05-23

Coverage

Medicare Part D, which is effective January 1, 2006, provides prescription drug coverage to eligible Medicare beneficiaries through private Prescription Drug Plans (PDPs). The PDP may be one of the following:

- Fee-for-service PDP operated by a private prescription drug provider, or
- Medicare Advantage-Prescription Drug Plan (MA-PDP) operated by a Managed Care Medicare provider.

Dual eligible individuals, who are eligible to both Medi-Cal and Medicare, must use a Medicare Part D PDP to obtain most of their prescription drugs beginning January 1, 2006 and ongoing. Medi-Cal will continue to cover certain drugs not coverd by Medicare Part D.

Enrollment

Enrollment in Medicare Part D is voluntary for most Medicare beneficiaries. Dual eligibles and Medicare Savings Program (MSP) eligibles will be automatically enrolled into a PDP if they do not voluntarily choose one. These include Medicare beneficiaries that are:

Dual Eligible	Medicare Savings Program Eligible
Zero SOC Medi-Cal	Qualified Medicare Beneficiary (QMB)
SOC Medi-Cal and the SOC has been paid	Specified Low Income Beneficiary (SLMB)
Supplemental Security Income (SSI)	Qualified Individual (QI-1)

Dual eligibles that belong to a Medicare Advantage (MA) plan will be automatically enrolled into the MA-PDP if a different plan is not selected. Individuals with questions regarding the PDP plan they have been enrolled into should be referred to Medicare at 1-800-633-4227. Individuals that need help determining which plan best meets their prescription needs should be referred to the Health Insurance Counseling and Advocacy program (HICAP) at 1-800-434-0222.

Costs

Medicare Part D includes the following costs which Medicare

beneficiaries **may** have to pay depending on their income and resources:

- A monthly premium
- An annual deductible
- Prescription drug co-payments
- Other prescription drug costs not covered by Medicare Part D

Deductions

The monthly premium payment, if paid out-of-pocket by a Medi-Cal beneficiary, would be treated as an "other health care deduction." The monthly premium may vary depending on the PDP. All other Medicare Part D costs, paid out of pocket, can be applied to the SOC for Medi-Cal beneficiaries with a SOC. Medicare beneficiaries that are eligible to a low-income subsidy do not have to pay most of the costs associated with Medicare Part D.

Low-Income Subsidy (LIS)

1. Zero SOC dual eligibles/MSP eligibles/250% Working Disabled (WD)

Dual eligibles with zero SOC, MSP eligibles and 250% WD individuals are automatically eligible to a LIS, which eliminates all Medicare Part D costs except for a small prescription drug co-payment. These beneficiaries do not have to fill out a LIS application. LIS eligibility lasts for the remainder of the calendar year even if their Medi-Cal or MSP eligibility discontinues.

2. SOC dual eligibles (not in LTC)

Non-LTC dual eligibles with a SOC must meet the SOC in at least one month to be eligible to a LIS, which eliminates all Medicare Part D costs except a small prescription drug co-payment. SOC dual eligibles that meet the SOC do not have to fill out a LIS application. LIS eligibility lasts for the remainder of the calendar year even if their Medi-Cal eligibility discontinues or if they do not continue to meet the SOC.

3. SOC dual eligibles in Long Term Care (LTC)

LTC dual eligibles that have a SOC must meet the SOC in at least one month in order to be eligible to a LIS, which eliminates **all**

Medicare Part D costs. **Medicare Part D prescription drug co-payments are waived for beneficiaries in LTC.** LTC dual eligibles that meet the SOC do not have to fill out a LIS application. LIS eligibility lasts for the remainder of the calendar year even if their LTC Medi-Cal eligibility discontinues.

4. Medi-Cal or MSP applicants

Medi-Cal or MSP applicants that are aged, blind or disabled must be provided a LIS application with their Medi-Cal/MSP application. In the event that their Medi-Cal/MSP application is delayed or denied, the applicant may proceed with a LIS evaluation through Social Security Administration (SSA).

5. Medicare beneficiaries requesting LIS, but not requesting Medi-Cal/MSP

Medicare beneficiaries requesting a LIS application that do not want to apply for Medi-Cal/MSP will be given a LIS application packet, available in English or Spanish, which includes the following:

- LIS Application Packet Coversheet (14-80 HHSA)
- MC 210
- MC 14A
- LIS application (SSA-1020B-OCR-SM)

If the LIS application is returned to the FRC, forward it to SSA in the return envelope provided with the LIS application. If the individual **objects** to having the application forwarded to SSA for processing or insists upon DHS completing the evaluation, the application shall be mailed to:

DHS/MEB
Attn: MMA Analyst
1501 Capitol Avenue, MS 4607
Post Office Box 997417
Sacramento, CA 95899-7417

6. Medicare beneficiaries requesting assistance with the LIS application

If the Medicare beneficiary requests assistance with completion of LIS,

refer the individual to designated FRC staff who will assist the individual with the following activities as needed:

- Read and explain the LIS application
- Provide the SSA telephone number where applications can be completed by phone (800) 722-1213
- Enter the English-only LIS application on-line at the SSA website www.ssa.gov with help from the individual
- Print foreign language LIS instructions from SSA website
- Refer to Medicare at (800) 633-4227 for answers to questions about the Medicare Part D drug benefit.

Note: County workers do not evaluate eligibility to the LIS. SSA or DHS determine LIS eligibility.

F. Medicare Eligibility

Eligible for Part A, Part B and Part D

The following persons are eligible for both Part A, Part B and Part D benefits:

1. Persons or their spouses eligible to RR/SSA based Medicare with the required quarters of employment; and, ACWDL 91-46
2. Individuals who are any one of the following:

    - 65 years of age or over;
    - Disabled or blind for at least 24 consecutive months under SSA Title II; or
    - Chronic renal disease meeting requirements for the receipt of Medicare. This category may include SSA/RR recipient's dependent children who do not have to meet the conditions in 1 above.

Eligible for Part B Only

Persons who are eligible for Medicare Part B benefits only include:

1. Persons who are not eligible for Medicare Part A;
2. 65 years of age or over; and

3. U.S. citizens or aliens legally present in the U.S. for at least five years.

G. Requirement to apply for Medicare

Medicare will pay a major portion of a Medi-Cal beneficiary's medical expenses and only the remainder will be charged to the Medi-Cal program. Therefore, Medi-Cal beneficiaries who are potentially eligible for Medicare are required to participate in Medicare. DHCS assures maximum participation with the Buy-In premium payment.

Medi-Cal applicants and beneficiaries required to apply for Part A

- Any person 64 years and 9 months or older.
- Any person applying for Medi-Cal as blind or disabled.
- Persons who are receiving disability payments under Title II of the Social Security Act or Railroad Retirement program.
- Persons receiving dialysis-related health care services.
- Persons who would only be eligible to Medicare Part A if they paid a premium are not required to accept Part A benefits. ACWDL 90-80
- Qualified Medicare Beneficiary (QMB) applicants. The QMB applicant will not have to pay the premium for Part A. He/she will be conditionally enrolled by SSA until QMB eligibility is confirmed.

Medi-Cal Applicants and Beneficiaries Required to Apply for Part B

- Persons who are applying for Medi-Cal on the basis of being aged.
- Persons applying for Medi-Cal on the basis of blindness or disability.

NOTE: Effective December 1, 2008, DHCS will not request Buy-In for an individual reported to MEDS with a SOC over $500 until or unless that SOC has been met. These individuals are not required to apply for Part B, unless they are also MSP eligible. ACWDL 08-48

Verification of Medicare Decision

Medi-Cal applicants who are required to apply for Medicare, are required to submit verification of their Medicare approval or denial to the

County within 60 days of the day they are notified of the requirement to apply for Medicare. If their eligibility for Medicare is not determined within 60 days, then they must submit verification of Medicare approval or denial within 10 days of the notification of approval or denial.

Special Treatment - Aged aliens

Any alien, age 65 or over, who is not entitled to monthly Social Security Retirement/Disability (Title II) benefits or Railroad Retirement benefits, must be a lawful resident of the United States for a continuous 5-year period before being eligible for Medicare Part B (outpatient) coverage. MEM Proc. 15

Aliens over 65 are required to apply for Medicare as a part of their Medi-Cal application process even when they may not be eligible for Medicare Part B. ACWDL 91-72

This information is reported to MEDs through an on-line transaction on Form 14-28.

MPG Letter #661 (12/08)

H. Persons Eligible for Buy-In

Buy-In refers to the arrangement through which DHCS pays the monthly premiums of Medicare Part B (supplementary medical insurance) for qualifying Medi-Cal beneficiaries.

Persons Eligible For Buy-In

A PA or MN applicant who is 65 or over, blind, disabled, or who has chronic renal disease is qualified for Buy-In, if the individual is entitled to Medicare.

I. Application worker responsibilities for the Buy-In Process

Worker Responsibilities For Buy-In

The worker has the responsibility of identifying applicants potentially eligible for Buy-In and providing the information required for Buy-In processing by DHCS.

1. Application Worker

At the intake interview, the worker will identify applicants potentially eligible for Buy-In.

If the...	Then the worker must...

<table>
<tr><td>applicant is not a current Medicare recipient</td><td>• Verbally inform the applicant of his/her responsibility to apply for Medicare;

• Send AL 978 to inform the client of the requirement to apply for Medicare;

• Set up a TIC for 60 days for all applicants who are required to apply for Medicare.</td></tr>
<tr><td>applicant is currently a Medicare recipient</td><td>• Verify Medicare HIC number.

• Enter HIC on automated system as appropriate even if previously entered and case has been closed. This entry will send a notice to DHCS to begin the Buy-In.

• Advise the applicant of the Buy-In system, including the anticipated raise in the net amount of the SSA check, and the time involved for the change to occur.

• Check the MEDS Buy-In screen in 60 days to insure that Buy-In is set up.</td></tr>
<tr><td>applicant refuses to file for Medicare coverage and is not entitled to monthly Social Security benefits or Railroad benefits</td><td>Apply for medical insurance (Part B) on behalf of the applicant. To apply for Medicare for a beneficiary, the worker will:<table><tr><th>Step</th><th>Action</th></tr><tr><td>1</td><td>Complete an application, Form SSA-4040, and mail it to the local SSA office; or</td></tr></table></td></tr>
</table>

		refuses to apply. • By filing an application, the individual may establish entitlement to hospital insurance (Part A); • The filing of an application will permit SSA to determine the individual's eligibility for monthly retirement benefits.

J. Continuing worker responsibilities for the Buy-In process

Collection of Buy-In information should be initiated by the continuing worker for a Medi-Cal recipient when they reach the age of 64 years and 9 months.

MEDS generates a message for every Medi-Cal beneficiary when they reach age 64 and 9 months. This message alerts the worker to contact the beneficiary regarding the requirement to apply for Medicare. The worker must take the following actions:

Step	Action
1	The worker will send client correspondence 978 advising the beneficiary of the requirement to apply for Medicare.
2	Set up a TIC for 60 days from the date the worker notified the beneficiary to apply for Medicare. The three months prior to age 65 allows lead time for processing Buy-In information through channels.

K. Buy-In Effective Date for MN Persons

Buy-In Effective Date for MN Persons

ACWDL 90-46

1. Buy-In for an MN person begins the second month after the month he is approved for Medi-Cal. The approval date means the date on which the worker makes the determination that the beneficiary is eligible for Medi-Cal.

2. The two-month lag time is automatically calculated by DHCS from the date of approval reported by the Counties through MEDS.

3. When a Medi-Cal eligible beneficiary receiving Medicare changes from PA to MN status, there should be continuous Buy-In and the two-month lag time does not apply.

4. Any overstated SOC can be adjusted in later months on a month-by-month basis. Refer to MPG Article 12, Section 1, for adjustment procedures.

5. Buy-In is effective immediately for an MN person who becomes Medicare eligible.

6. Buy-In coverage ends on the last day of the month in which a person loses eligibility for either Medicare of Medi-Cal. So long as a beneficiary is continually Medi-Cal and Medicare eligible, there should be no breaks in Buy-In coverage unless the Medicare eligible person has a SOC over $500. ACWDL 08-48

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L. Predicting Buy-In for applications

Buy-In is to be predicted in the second month following the month the granting action is taken, regardless of the beginning date of eligibility.

Example: The applicant signs the application in May, and the granting action is taken in June, effective May 1. Buy-In will be predicted for the month of August, the second month following the month the granting action is taken (June).

In the example above, Buy-In will be predicted for July when the granting action is taken in the same month the application is signed (May).

Workers should not predict Buy-In for applicants with a SOC over $500. ACWDL 08-48

MPG Letter #661 (12/08)

M. Buy in Problems

Buy-In Problems

The DHCS Buy-In Unit is available to assist in resolving problems. The Buy-In Unit's responsibilities are limited to resolving problem cases which cannot be accomplished by routine Buy-In data

processing.

Workers will use Form DHCS 6166 to communicate problems to the Buy-In unit. In order to successfully resolve a problem case, it is imperative that enough information is provided to enable state staff to work the case. Include the following data in the DHCS 6166, Complaint Form:

1. Date of request.

2. Beneficiary's full name.

3. Social Security and Health Insurance Claim numbers.

4. Date of Birth and Sex.

5. 14-digit case identification number.

6. Medi-Cal effective dates for each period relevant to the problem.

7. County Representative information, name, return address and phone number.

8. A description of the problem and the change being requested. This should be detailed enough so that the technician in the Buy-In Unit will know exactly what the problem is and the action the County wants DHCS to take. In those situations where the County is notified that an individual was inadvertently dropped from Buy-In, the County will:

    - Notify SDHS to resume Buy-In, using Form DHS 6166, State Buy-In Problem Report;

    - Adjust any overstated Share of Cost in those months where timely reporting occurred or occurs; and,

    - Assume Buy-In is effective in the second full month following the approval date for Medi-Cal.